PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance and Portability Accountability Act (HIPAA) of 1996 controls how the Protected Health Information of our patients can be discussed and with whom. This form authorizes the doctor and staff to discuss your PHI with those you have listed below and in what specific manner.

Individuals to whom your health information may be disclosed:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Can the doctor and staff leave messages on an answering machine? Y N

Is there anything you do not want left on an answering machine?

_____

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. This authorization will remain in effect unless otherwise revoked by the patient. Release of the Protected Health Information covered by this authorization will be disclosed solely for the purpose of keeping designated family members informed of your healthcare condition.

Patient:_____

SS#:_____ DOB:_____

Patient Signature:_____ Date:_____

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Brian J. Marien, MD, LLC, originates and maintains paper and/or electronic medical records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payor can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that as part of this surgical practice's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses including disclosures via facsimile.